Section D: Schedule of Dental Services (Levels of Care)

The IHS Division of Oral Health developed the schedule of dental services to assist community dental programs in managing their resources effectively in a "demand care" setting. The schedule categorizes all types of dental services into levels of care, a priority listing. Services that alleviate pain or prevent disease have a higher priority than those intended to prevent or contain disease or to correct damage caused by disease. Thus, emergency care has the highest priority (Level I) for expending the available resources, while providing access to complex rehabilitative care (Level V) is lowest.

- Level I: Emergency Oral Health Services
- Level II: Preventive Oral Health Services
- Level III: Basic Oral Health Services
- Level IV: Basic Rehabilitation Oral Health Services
- Level V: Complex Rehabilitation Oral Health Services
- Level IX: Exclusions

Most treatment needs in American Indian/Alaska Native (AI/AN) communities fall within the first three levels, sometimes called "basic care." This term refers to the most cost-effective services to provide on a community-level basis. As additional funds become available for dental care, the schedule can be used to expand access to care methodically, equitably and cost-effectively.

The schedule represents a consistent structure for program planning, as well as for treatment planning for individual patients. It is intended to be a flexible tool, adaptable to each community and dental patient. Factors such as the availability of alternate resources, community water fluoridation, patient age, the prognosis for success and other conditions play a role in determining how the schedule should be applied to individuals and target groups. The general principle for implementing the schedule is always to use the available resources for providing the greatest health benefit to the greatest number of people for the longest time possible.

Over the past decade, the schedule of dental services has proven its value to IHS, Tribal, and Urban (I/T/U) dental programs in many ways. Following is a list of some common uses.

- Provides consistent structure for program and provider performance evaluations (in-house and Joint Commission).
- Provides a way to document dental program activity and adequacy of funding during Tribal self-determination contracts and self-governance compact negotiations.
- Provides a framework for contracting a scope of work and standards of care with private care providers. These contracts may be administered by local authorities or indirectly through outside agencies (Delta Dental, Blue Cross/Blue Shield, etc.).

- Provides a basis for planning facility expansion and manpower enhancements to improve access to care, using anticipated care utilization rates and population growth estimates.
- Provides a way to demonstrate and compare the dental needs and relative level of access to care among AI/AN communities of all sizes and backgrounds (for annual budget submissions to Congress and other potential funding sources).

A. Level I: Emergency Oral Health Services

Emergency dental services are those necessary to relieve acute conditions and encompass all necessary laboratory and preoperative work including examination, radiographs and appropriate anesthesia. They include but are not limited to the following:

- Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patient's well-being. Treatment may consist of any professionally accepted procedure deemed necessary.
- Relief of life-threatening respiratory difficulty and improvement of the airway (respiratory system) from any oral or maxillofacial dental condition. Treatment may consist of any professionally accepted procedure deemed necessary.
- Relief of severe pain accompanying any oral or maxillofacial dental conditions affecting the nervous system, limited to immediate palliative treatment, but including extractions where professionally indicated.
- Immediate and palliative procedures that include fractures, subluxations and avulsions of teeth; fractures of jaw and other facial bones (reduction and fixation only); temporomandibular joint subluxations; soft tissue injuries; broken dentures; and chipped teeth.
- Initial treatment for acute infection.

Procedures frequently reported in this category of care include the following:

- Emergency oral examination (limited to problem area).
- One or more periapical radiographs associated with the problem.
- Simple tooth extractions.
- Temporary or sedative restorations.
- Palliative procedures.
- Prescription medications for pain and infection.
- Endodontic access preparations.
- Draining of oral abscesses.
- Denture repairs and other urgent repairs.

B. Level II: Preventive Oral Health Services

These services prevent the onset of the dental disease process. Some are modified by IHS definitions, exclusions, limitations and processing policies. Please refer to the appropriate sections for further descriptions of exclusions, limitations and processing policies.
The preventive oral health services most often provided are as follows:

- Adult prophylaxis with or without topical fluoride.
- Child prophylaxis with or without topical fluoride.
- Sealants by tooth or quadrant.
- Preventive (self-care) training.
- Periodontal recall procedures.
- Athletic mouthguards.
- Water fluoridation activities.
- Group education.
- Tracking of number of children receiving supplemental fluorides per month.

C. Level III: Basic Oral Health Services

Basic dental care includes services provided early in the disease process that limit the disease from progressing. They include most diagnostic procedures, simple restoration of diseased teeth, early treatment of periodontal disease and many surgical procedures to remove or treat oral pathology.

The Level III procedures commonly reported include the following:

- Initial or periodic oral exam.
- Bitewing and panoramic radiographs.
- Diagnostic casts.
- Space maintainers.
- Amalgam restorations (1-, 2-, 3-surface).
- Composite restorations (1-, 2-, 3-surface).
- Stainless steel crowns (primary teeth only).
- Therapeutic pulpotomy (primary teeth only).
- Anterior endodontics (one canal).
- Periodontal scaling/root planing.
- Biopsy, excision of lesion.

D. Level IV: Basic Rehabilitative Services

Basic rehabilitation services contain the disease process after it is established or improve the form and/or restore the function of the oral structures. The word “function” as used here includes some psychosocial considerations. These services are more difficult to provide because the disease process is well established, but investing resources is cost-effective because the procedures are directed at containment or basic rehabilitation. They include complex restorative procedures (onlays, cores and crowns), most endodontic procedures, most advanced periodontal procedures, prosthodontic appliances that restore function, pre-prosthetic surgery and most interceptive or limited orthodontic procedures.

The following Level IV services are those most frequently utilized:

- Complex amalgams (four or more surfaces).

- Cast onlays or crowns with or without porcelain.
- Post and core restoration.
- Crown buildups.
- Acid-etch retainers (Maryland Bridge).
- Bicuspid endodontics (two canals).
- Apicoectomy/retrograde filling.
- Gingivoplasty.
- Limited/interceptive orthodontics.

E. Level V: Complex Rehabilitative Services

The complex rehabilitation services listed in Level V are those that require significant time, special skill or cost to provide. Certain patients will require referral to dental professionals skilled in providing the specific procedure or who have limited their practices to that specific area. Generally the patient must present special circumstances that warrant the added time and transportation associated with specialty referral. Level V services may not improve the overall prognosis for most patients, so patient selection is a critical consideration.

The Level V services most frequently provided are as follows:

- Molar endodontics (three or more canals).
- Periodontal surgery (mucogingival and osseous).
- Complete and partial dentures.
- Denture rebase (laboratory).
- Fixed bridgework (retainers and pontics).
- Implants.
- Surgical extractions (impactions).
- Analgesia (nitrous oxide).
- Cephalometric or TMJ radiographs.
- Occlusal adjustment (complete).
- Periodontal surgery.
- Overdentures.
- Consultation for specialty services.
- Precision attachment prosthetics.
- Comprehensive orthodontics (Class I, II or III).
- Surgical extractions (bony impactions) and unusual or complex oral surgery.
- Maxillofacial prosthetics.
- Intravenous (IV) sedationand/or general anesthesia.

F. Level IX: Exclusions

These services have been determined to be of limited benefit in treating oral disease or maintaining oral health. They have a variable success rate; their appropriateness and effectiveness are difficult to monitor; and they are not universally defined or accepted as the preferred method of treatment. Some of the services listed under exclusions require

heroic effort; therefore, their cost effectiveness is questionable. Other services use obsolete or potentially ineffective material. In other cases the services are considered part of treatment and do not warrant a separate fee or value. In certain other cases the IHS simply will not pay for the service.

The following procedures are examples of frequently reported exclusions:

- Removable unilateral space maintainers.
- Silicate restorations.
- Gold foil restorations.
- Cast inlays.
- Porcelain inlays or crowns.
- Full resin or resin/metal crowns.
- Direct pulp caps.
- Unilateral cast partials.
- Chair-side denture relines.
- Pulpotomy in permanent tooth.
- Tooth transplantation.
- Removable appliance therapy.
- Behavior management.
- Broken appointments.

Limitations

Provisions have been added to the schedule of dental services to limit the frequency of certain procedures provided to individual patients. The limitations are similar to those accepted in contracts managed by most third-party payers and, therefore, should be acceptable to most practicing dentists. The limitations are to be used in conjunction with applicable modifiers for specific services to ensure that care is provided with optimal effectiveness.

The following table lists dental services subject to the specific limitations given.

Procedure	Limitation
Initial oral exam	Once per patient.
Periodic oral exam	Once per six-month period.
Full mouth radiographs	Once during three-year period.
Supplemental bitewings	Once per six-month period.
Prophylaxis	Once per six months, includes education.
Topical fluoride	Selected patients with high caries activity.
Crowns	Only when a less complex restoration is not possible (supported by x-rays).
Class II posterior composites	By report only.
Periodontics	Limitations on type and frequency of services vary with disease severity.

Prosthodontics	No replacement within five years/ chrome/acrylic material of choice.

Treatment Modifiers

To enhance the appropriateness and effectiveness of oral health care for AI/ANs, the schedule of dental services contains modifiers that practitioners must consider before planning treatment. These modifiers are based on differences in the needs and circumstances of individual patients such as the patient's age, health behavior or motivation. Existing medical conditions and other factors may dictate the priority and extent of dental care that can be provided.

Following is a list of modifiers:

- Age of patient.
- Arch integrity.
  - Strategic importance of teeth involved in treatment.
- Patient's health behavior or motivation.
  - Compliance.
  - Willingness to receive treatment.
  - Dependability (appointment history).
- Oral hygiene and periodontal status.
  - Activity of destructive disease.
- Caries activity.
  - Recurrent caries.
  - Smooth-surface lesions.
  - Root-surface lesions.
  - Pit and fissure lesions.
- Medical conditions.
  - Diabetes.
  - Other systemic conditions that may affect the patient's ability to receive or respond to dental therapy.
- Access to care.
  - Distance from clinic.
  - Availability of skilled provider.
  - Backlog of demand for lower levels of care.